



Second Quarter 2026

CAQH Service Line Addresses:
Why Removing All Addresses
May Be Seen as Termination
Page 3

Availity Essentials – Your
Provider Digital Front Door
Page 4

Enhancements for Group
Practices Submitting New
Provider Applications in Availity
Page 5

Payments Transitioning to
Zelis Platform
Page 6

Reminder: Availity
Enhancements to Streamline
Your Claims Dashboard
Page 7

Enhance Your Connectivity
With Carelon: Keep Your
Provider Data Current
Page 8

A woman with long dark hair, wearing a white polka-dot shirt and black pants, is kneeling on a grey carpeted floor. She is smiling and looking at a young girl with brown hair in a ponytail, who is wearing a pink long-sleeved shirt and olive green pants. The girl is sitting on a red foam block. In the background, there is a wooden play structure, a potted plant, and a framed picture of a rainbow on the wall.

Carelon Behavioral Health
Provider Newsletter

Contents

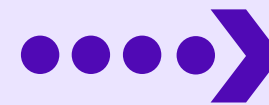
CAQH SERVICE LINE ADDRESSES: WHY REMOVING ALL ADDRESSES MAY BE SEEN AS TERMINATION	
If you remove all Service Line addresses in CAQH, Carelon Behavioral Health interprets this as a termination of your practice locations.....	3
AVAILITY ESSENTIALS – YOUR PROVIDER DIGITAL FRONT DOOR	
Availity Essentials is a secure, comprehensive, self-service multi-payer portal that simplifies your office’s daily operations.....	4
ENHANCEMENTS FOR GROUP PRACTICES SUBMITTING NEW PROVIDER APPLICATIONS IN AVAILITY	
Enhancements to the enrollment application in Availity are now live for existing in-network group practices submitting new provider applications.	5
PAYMENTS TRANSITIONING TO ZELIS PLATFORM	
We’re transitioning our payment processing from PaySpan to Zelis.....	6
REMINDER: AVAILITY TOOLS TO HELP STREAMLINE YOUR CLAIMS DASHBOARD EXPERIENCE	
Enhancements have been made to the claims application in Availity	7
ENHANCE YOUR CONNECTIVITY WITH CARELON: KEEP YOUR PROVIDER DATA CURRENT	
To best serve our members together, the most up-to-date provider data is essential	8
MEDICAL NECESSITY CRITERIA	
Carelon Behavioral Health’s clinical criteria.....	10
PROVIDER RESOURCES TO SUPPORT MEMBER ACCESS AND CARE	
Learn about the resources available to support communication, care coordination, utilization management, member rights, and access to care.....	11
HELPFUL REMINDERS	
Member Rights and Responsibilities.....	13
Carelon’s Ethical Approach to Utilization Management Decisions.....	13
Appointment Access Reminder.....	13

EMAILING THE CARELON PROVIDER RELATIONS TEAM	
Best emailing practices.....	14
CONTACT US	
Have questions or need assistance? Reach out to your Carelon Behavioral Health team today	15
REGIONAL NEWS	
Florida	
FUH Watchout: Key Steps to Ensure Timely Follow-up After Mental Health Hospitalization.....	16
Massachusetts	
Medical Necessity Criteria.....	17
New York	
NYSDOH Issues Guidance on SUD Type of Bill Reporting.....	18
State-Approved Curriculum for Cultural and Linguistic Competence for Behavioral Health Providers.....	19
Pennsylvania	
Responding to Provider Feedback on Mental Health Advanced Directives.....	21
Practical Leadership Skills for Supervisors of Licensed Clinicians in Behavioral Health.....	23
What is “Gas Station Heroin”.....	26
Strengthening Recovery Through Better Coordination: Why Continued Case Management Matters During Substance Use Treatment.....	27
E&M Coding Pattern Review and Documentation Reminder.....	29
Your Rights: Complaints and Grievances (And a Reminder for Providers).....	30
How to File a Grievance.....	32
Creating a Culture of Celebration.....	34
Texas	
Texas Medicaid PEM Revalidation and Training Resources.....	36

CAQH SERVICE LINE ADDRESSES: WHY REMOVING ALL ADDRESSES MAY BE SEEN AS TERMINATION



Carelon Behavioral Health relies on CAQH to keep your provider record updated. If you remove all Service Line addresses in CAQH, Carelon Behavioral Health interprets this as a termination of your practice locations.



Carelon Behavioral Health sees removal of all Service Line addresses in CAQH as a **TERMINATION**

WHAT HAPPENS WHEN ALL ADDRESSES ARE REMOVED?

When the last Service Line address is removed in CAQH, Carelon may take action to terminate your locations, which may impact:

- Panel/Network status
- Claims and payments
- Contracting and credentialing

WHAT SHOULD YOU DO?

- **Keep at least one active Service Line address in CAQH - Update or add addresses as needed, but do not remove all locations.**
- **If closing or relocating,** contact Carelon Provider Services before making changes.
- **For questions related to Carelon,** please contact the Provider Service Line at 800-397-1630
- **For assistance with CAQH functionality,** call 888-599-1771

HOW TO CHECK YOUR SERVICE LINE ADDRESSES IN CAQH

- 1 Log in to CAQH ProView and select Provider Data Management
- 2 Select your provider record
- 3 Go to the Practice Location (Service Locations) section.
- 4 Review your Service Locations. If you remove all locations (no rows displayed), Carelon Behavioral Health will see this as a termination.

The screenshot illustrates the steps to check service locations in CAQH ProView:

1. CAQH ProView® My Account menu with 'Provider Data Management' highlighted.
2. Provider Data Management page with 'My Provider Records' table. A 'View' button is highlighted for Jane Doe, MD.
3. Practice Locations (Service Locations) section with tabs for Basic Information, Addresses, Practice Locations, Specialties, Identifiers, and Disclosure. The Practice Locations tab is selected.
4. Practice Locations (Service Locations) table with columns: Location Name, Address, Phone, Status. It shows two active locations: Main Office and West Office. Below the table, a message states 'No practice locations (service locations) found.' and a red box indicates 'No locations = Termination'.



ADDING NEW SERVICE LOCATIONS IN ANOTHER STATE AND/OR NEW TAX ID?

Providers who add a new service location under either a new service state and/or new Tax ID must update CAQH AND update Carelon directly.



KEY TAKEAWAY:

Always keep at least one active Service Line address in CAQH. Removing all addresses may result in termination of your record with Carelon

AVAILITY ESSENTIALS – YOUR PROVIDER DIGITAL FRONT DOOR

Availity Essentials is a secure, comprehensive, self-service multi-payer portal that simplifies your office's daily operations. As a registered user, you can quickly verify patient eligibility and benefits, submit and review authorization requests, and access detailed claim information—all without needing to contact Carelon Provider Services. Registration is **free**, providing immediate access to the full range of tools and resources available through Availity.

Several enhancements have been added to Availity, including:

- » **Single Sign-On:** Gain easy access to Carelon portals directly through Availity.
- » **Authorization Management Dashboard:** Effortlessly search for and request authorizations.
- » **Claims Dashboard:** Quickly search for and review detailed claim information.
- » **Message Center:** Manage all your web correspondence with us conveniently in one place.
- » **Enrollment:** Providers wishing to join our network as Individuals, Groups, or as a provider joining a group must use Availity for enrollment.

New to Availity?

Providers who are not yet registered with Availity can learn more, and sign up today, at **no charge** by visiting [Availity.com](https://www.availity.com).

If you need further assistance, contact Availity Client Services at 800-282-4548. Assistance is available Monday through Friday 8 a.m. – 8 p.m. Eastern Time.



ENHANCEMENTS FOR GROUP PRACTICES SUBMITTING NEW PROVIDER APPLICATIONS IN AVAILITY

Expanded Data Fields for Group Submissions

To support more complete and accurate provider information, several new fields have been added to the application. These updates help ensure new providers added under your group are set up efficiently and accurately.

Practice Details

- Office Hours (including daily schedules and after-hours availability)
- Holiday Appointment Scheduling Availability

Patient Population

- Age Limitations
- Population Treated (age categories and percentage of practice)
- Gender Identity Treated
- Racial/Cultural Populations Served

Accessibility & Language Services

- Non-English languages spoken by office staff
- Translation services availability
- Interpreter experience and availability

For more information, register for our upcoming trainings:

Availity Provider Enrollment Training

- [Tuesday, June 16, 2026 2:00 p.m. Eastern time \(ET\)](#)
- [Thursday, June 25, 2026 11:00 a.m. Eastern time \(ET\)](#)

Availity Provider Portal Enhancements Training:

- [Tuesday, June 16, 2026 11:00 a.m. Eastern time \(ET\)](#)
- [Thursday, June 25, 2026 3:00 p.m. Eastern time \(ET\)](#)

New Provider Status Field Available: “Ready to See Members”

Providers Joining your Group, will now show a status indicating the status of their system setup.

Status will indicate one of the following:

- **Complete:** The provider has been fully credentialed and has a fully executed provider agreement.
- **Pending:** Some required setup steps are still in progress. Please check back for status.

Provider Name	Application ID: xxxxxxxx
CAQH Number: xxxxxxxxxxxx	NPI Number (Type 1): xxxxxxxxxxxx
STATUS SUMMARY	
Credentialing Status:	Approved
Your credentialing request was approved.	
Network Agreement Status:	Fully Executed
Your network agreement with Carelon Behavioral Health is active.	
Ready To See Members:	Pending
All necessary portions of agreement have not been finalized. Please check back for status.	

PAYMENTS TRANSITIONING TO ZELIS PLATFORM

The payment process outlined below is specific to payments for Carelon members. For Anthem, continue with your existing payment process.

Zelis recently acquired **Payspan**, combining two leaders in healthcare payments to create a more powerful and unified platform. As a result, **Carelon Behavioral Health** will transition its payment processing from **Payspan** to **Zelis** in summer 2026 to ensure a smooth and seamless transition. *(The original go-live date of 2025 has been adjusted to summer 2026.)*

This change is designed to streamline your experience and provide faster, more secure access to payment data and remittances.

What you need to know:

- **For Providers Not Enrolled with Zelis:** To continue receiving your claim payment data and remittances electronically at no cost, please register through carelon.epayment.center or call 855-774-4392.
- **For Providers Already Enrolled with Zelis:** You'll continue to receive payments as usual – just log into the [Zelis Portal](#) to access your data and remittances. Need help? Call 877-828-8770 or email ClientService@zelispayments.com (8 a.m. – 7 p.m. ET, Monday – Friday).

You will still be able to access historical payment data at payspanhealth.com.

Zelis will be reaching out directly with additional information and guidance to help you through this transition.



🔒 Log in to the Zelis Payments Provider Portal

User Name

Password

Login

[Forgot my password](#) | [By logging in, I agree to the Terms Of Use](#) | [Locked out? Please contact the administrator at your organization.](#)

REMINDER: AVAILITY TOOLS TO HELP STREAMLINE YOUR CLAIMS DASHBOARD EXPERIENCE

Providers can take advantage of enhanced claims dashboard functionality in Availity designed to simplify how claim details are viewed and managed. This streamlined experience makes it easier to access claims information, track claim status, and navigate claim details efficiently within the portal.

What's Changed

- **No more organization administration setup dependency**; you'll be able to search and view claims directly by **Tax ID and NPI, or atypical ID**.
- Easier setup: To ensure full access, please confirm all **Tax IDs and NPIs** are properly configured through Availity's **Manage My Organization** feature. This is a one-time setup.
 - If anything appears missing, coordinate with your Carelon Organization Administrator to complete setup.

Enhanced Claim Details

- **Line-level claim details** are now available **within the Claims Dashboard** itself.
- Simply click on the **Claim Number hyperlink** to view detailed line-level information.

Previously, the claim number hyperlink would single sign-on (SSO) into **ProviderConnect** or **eServices** to display these details.

- The **SSO functionality has been removed**—all necessary claim information can now be viewed directly in the Claims Dashboard.

Training and Support

Join us for an upcoming training session to learn more about these enhancements and how to navigate the updated Claims Dashboard:

Availity Provider Portal Enhancements

This one-hour webinar will provide an overview of enhancements in the Availity Portal for Carelon Behavioral Health (CBH) providers.

- Claims Dashboard
- Authorizations Dashboard
- Account Administration and other important features for CBH providers

- [Tuesday, June 16, 2026 11:00 a.m. Eastern time \(ET\)](#)

- [Thursday, June 25, 2026 3:00 p.m. Eastern time \(ET\)](#)

Availity Provider Enrollment Webinar for Carelon Behavioral Health Providers

This one-hour webinar will cover Provider Enrollment using Availity application for new providers. We will demonstrate the following features:

- Enroll as individual provider
- Join an existing group
- Create a new provider group

- [Tuesday, June 16, 2026 2:00 p.m. Eastern time \(ET\)](#)

- [Thursday, June 25, 2026 11:00 a.m. Eastern time \(ET\)](#)

ENHANCE YOUR CONNECTIVITY WITH CARELON: KEEP YOUR PROVIDER DATA CURRENT

Maintaining accurate provider information and keeping location access and availability up to date is essential for building an effective, accessible care network for our members. When you showcase your true availability, practice areas, and services, you make it easier for members to connect with the right provider—you.

Carelon is committed to provider safety and privacy, and we recognize that sharing personal information is a personal choice. While demographic details such as culture, race, ethnicity, and religion are optional and you may choose not to disclose them, we encourage you to share what you feel comfortable providing. Many members look for a provider they feel comfortable with, and demographic information can be an important part of identifying that “good fit.”

Our members come from diverse backgrounds and have unique care needs, making it vital to keep access and accommodation details up-to-date at every location you serve. Ensure your information includes whether you serve members in-person, any telehealth services offered, physical accessibility, hearing accommodations available, languages spoken fluently by you and your staff, and your ability to work with translators. Many members rely on this information to choose their providers. By keeping your details accurate, you help ensure that every member enjoys a seamless and equitable care experience.



Continues on the following page

Enhance Your Connectivity with Carelon: Keep Your Provider Data Current *continued*

As a reminder, all providers are encouraged to ensure your practice supports the Rights and Responsibilities of our Members. Carelon Behavioral Health's [Member Rights and Responsibilities Statements](#) are available for download on our website in English, Spanish and additional languages upon request, accessible to both you and our members.

Compliance and Auditing: Supporting Accuracy and Access

See what members see. We encourage you to regularly review your directory data under your credentialed plans at [Carelon's provider directory](#).

Our directory is not only a vital referral resource for members—it also supports the accuracy audits required by states, federal entities, clients, and accreditation bodies.

What to expect:

- You may receive email invitations to participate in audits.
- Larger groups and some providers may also receive phone outreach.
- Due to telehealth services and multi-state licensing, a single provider may be asked to complete multiple audits each year.
- Beyond directory audits, you may also receive requests from other departments to confirm compliance with access and availability standards.

Your participation ensures Carelon and our provider partners meet these requirements. Thank you for helping us maintain trust and compliance.

Streamlining the Update Process

Under the **No Surprises Act (CAA – Consolidated Appropriations Act)**, providers must review and attest to their data every 90 days. We know this can be burdensome—especially for those with multi-payer credentials. To simplify the process:

- **CAQH users:** Submit updates and attestations through CAQH.
- **Non-CAQH users:** Make updates directly in the Carelon Behavioral Health ProviderConnect portal.
- **Coming soon:** A new, comprehensive provider digital front door portal that will streamline demographic and location-specific updates.

If you encounter technical issues while updating your data, please reach out to Carelon directly for support at **800-397-1630**. Our goal is to make it as easy as possible for members to find and connect with you.

MEDICAL NECESSITY CRITERIA

Medical Necessity Criteria Available Online

Carelon Behavioral Health's clinical criteria, also known as medical necessity criteria, are based on nationally recognized resources and updated at least annually.

The National Committee for Quality Assurance (NCQA) accreditation standards (UM2A Factor 4: Practitioner Involvement) requires accredited health plans to seek annual non-staff network practitioner feedback on the development, adoption and review of clinical criteria used to make utilization management decisions.

“Non-staff network practitioners must also be involved in developing, adopting and reviewing criteria, because they are subject to application of the criteria. The organization may have practitioners review criteria if it does not develop its own UM criteria and obtains criteria from external entities.”

Practitioners with clinical expertise in the use of criteria sets are asked to provide commentary on either the development and adoption of these criteria sets, or on the instructions for applying these criteria sets. Medical necessity criteria vary according to individual state and/or contractual requirements and member benefit coverage.

[Learn more](#)

The following questions may help to guide provider feedback but are not meant to be limiting: (please identify which criteria set you are referencing)

1. Do you use the criteria when requesting prior authorization or concurrent review?
2. Do you have any suggestions for improving either one or both of the medical necessity criteria noted above?
3. Have you had any difficulty using either one or both of the medical necessity criteria?
4. Is there any new scientific evidence that would support a change to either one or both of the existing criteria?
5. Any additional comment/feedback on either one or both of the medical necessity criteria noted above?

To find out more information about the development of Carelon Behavioral Health's Medical Necessity Criteria, submit feedback or to obtain copies free of charge please email Provider.Inquiry@carelon.com

*Disclosure Statement: All feedback and recommendations about the medical necessity criteria (MNC) will be aggregated and shared in a de-identifiable format with the organization, governmental entity or 3rd party vendor that issued the MNC.

PROVIDER RESOURCES TO SUPPORT MEMBER ACCESS AND CARE

Providers play an important role in helping members access the care and services they need. The following resources are available to support communication, care coordination, utilization management, member rights, and access to care. We encourage providers to review these resources and share applicable information with members when appropriate.

Language Assistance Services for Members

We provide free language assistance services to members, including interpreter services and bilingual support, to help them understand their benefits and access care. Providers should inform members that these services are available at no cost.

Additional information, including how to access interpreter services, is available in the Provider Manual and Provider Portal. Members can also access language assistance by contacting Member Services.

- “I Speak” language identification posters and cards to help identify a patient’s preferred language and connect members with interpreter services

Communication Support Services

Members have access to communication services, including TTY/relay services and language assistance. These services are available during business hours and for urgent needs. Providers should direct members to Member Services for assistance with communication needs.

- Multicultural Mental Health Resource Centre (MMHRC) – multilingual patient education resources for anxiety, depression, PTSD, psychosis, substance use disorders, and other behavioral health conditions
- National Institute of Mental Health (NIMH) – downloadable mental health fact sheets and brochures in English and Spanish
- SAMHSA Library & Store – printable behavioral health and recovery materials, including crisis and substance use resources

Access to Utilization Management (UM) Criteria

Clinical criteria used for utilization management decisions are available to providers electronically and at the point of care. Providers may access criteria via the provider portal or request them directly to support treatment planning and authorization requests.

Utilization Management Contact Information

Providers can contact UM staff during normal business hours to discuss authorization requests or UM decisions. After-hours inquiries are accepted and returned on the next business day. UM staff will identify themselves by name, title and organization when communicating with providers.

Peer-to-Peer Discussion of Denials

Treating practitioners have the opportunity to discuss utilization management denial decisions with a qualified clinical reviewer. Instructions for requesting a discussion are included in denial communications.

Complaints and Appeals

Members may file complaints or appeals regarding care or services. The organization investigates all concerns and notifies members of outcomes and appeal rights. Language assistance is available to support members through this process.

Provider Resources to Support Member Access and Care *continued*

Member Rights and Responsibilities

Members have the right to participate in decisions about their care, receive information about treatment options, and voice complaints or appeals. Providers are expected to support these rights and engage members in shared decision-making.

Access to Care After Hours and Emergencies

Members should be directed to appropriate emergency services, including 911 or crisis resources, when urgent needs arise. Providers should ensure members understand how to access care after normal business hours.

Population Health Programs

Providers are encouraged to refer eligible members to available population health programs, including care management and wellness services. Information on available programs and referral processes is accessible through the provider portal.



HELPFUL REMINDERS

Member Rights and Responsibilities

Carelon Behavioral Health’s Member Rights and Responsibilities Statements are available in [English](#), [Spanish](#) and additional languages upon request, accessible to both you and our members for download from our website.

Providers and practitioners are encouraged to ensure your practice supports the Rights and Responsibilities of our Members.

[Learn more](#)

Reminders Regarding Carelon’s Ethical Approach to Utilization Management Decisions

Licensed behavioral health care professionals work cooperatively with practitioners and provider agencies to ensure member needs are met. Utilization management decisions are based on the clinical needs of the members, benefit availability, and appropriateness of care. Objective, scientific-based criteria and treatment guidelines, in the context of provider or member-supplied clinical information, guide the decision-making process.

Carelon Behavioral Health does not provide rewards to any of the individuals involved in conducting utilization review for issuing denials of coverage or service. There are no financial incentives to encourage adherence to utilization targets and discourage under-utilization. Financial incentives based on the number of adverse determination or denials of payment made by any individual involved in utilization management decision making are prohibited.

Appointment Access Reminder

Carelon Behavioral Health strives to provide members with accurate, current Provider Directory information. Participating providers are expected to maintain established office hours and appointment access. Carelon Behavioral Health’s provider contract requires that the hours of operation of all network providers be convenient to the members served and not discriminatory. Participating providers are required to maintain the following access standards:

If a member has a:	They must be seen:
Life-threatening emergency	Immediately
Non-life threatening emergency	Within 6 hours
Urgent needs	Within 48 hours
Routine office visit	Within 10 business days
Routine Follow-up office visit (non-prescriber)	Within 30 business days of initial visit
Routine Follow-up office visit (prescriber)	Within 90 business days of initial visit

The table above reflects the access standards that are the minimum standards for Appointment Accessibility for all states. Some state or market specific requirements may be stricter.

As a reminder, if at any time your practice is not able to meet the appointment access requirements, please update your Provider Directory information:

- Practitioners: Visit [CAQH](#), update, and attest
- Provider Groups and Facilities: Visit our [provider portal](#) or call our National Provider Service Line at 800-397-1630

EMAILING THE CARELON PROVIDER RELATIONS TEAM

When emailing the Carelon provider relations team, the most efficient and expeditious way to get your inquiry to the correct staff member is to do the following:

- » **Subject Line:** Practice State (fully written out no, abbreviations) - County - Issue (Claims, Demographics, Contracting, etc.)
- » **Body of Email:** please include the NPI (Solo and/or Group) as well as the billing TIN pertaining to your inquiry.

This will allow your inquiry to be routed to the correct state representative for review and resolution in the quickest manner.

Contact our National Provider Services Line at 800-397-1630, Monday to Friday, 8 a.m. to 8 p.m. Eastern time.

You can find additional provider-specific contact information and resources [here](#).



CONTACT US

Claims general questions

If you have general questions about claims, call 800-888-3944. For questions regarding claims submission addresses, please reference the member's identification card, as the address may vary based on payment location.

For claims questions related to Anthem members, please refer to Anthem's claim process.

Claims payment disputes

To file an appeal based upon the denial of a payment request, please use the [Provider Claims Based Dispute Resolution Request form](#) and mail to the address given in the PSV or mail to:

Provider Dispute Resolution
P.O. Box 1850
Hicksville, NY 11802-1850

For Anthem members, please refer to Anthem's claims payment dispute process.

Credentialing status

To obtain information pertaining to your network status, contact our National Provider Services Line at **800-397-1630**, Monday to Friday, 8 a.m. to 8 p.m. Eastern time (ET).

Update your contact information

If you are a participating Council for Affordable Quality Healthcare (CAQH) provider, please update your information with CAQH. If you do not participate with CAQH, please log into [ProviderConnect](#) and select the "Update Demographic Information" option.

Carelon Behavioral Health Provider Relations Questions: Contact our National Provider Services Line at 800-397-1630, Monday to Friday, 8 a.m. to 8 p.m. ET. You can find additional provider-specific contact information and resources [here](#).

Please have the following information available:
Provider Name, TIN, NPI, Brief Description of Issue and Dates of Service



For more information, [click here](#) to access our provider handbook or visit www.carelonbehavioralhealth.com/providers/resources/provider-handbook

FUH WATCHOUT: KEY STEPS TO ENSURE TIMELY FOLLOW-UP AFTER MENTAL HEALTH HOSPITALIZATION

Timely follow-up after an inpatient mental health hospitalization is critical to supporting safe transitions of care and improving outcomes for members. Our FUH Watchout document provides practical guidance to help providers meet the Follow-Up After Hospitalization for Mental Illness (FUH) measure requirements and avoid common gaps that can impact performance.

The resource highlights key considerations, including the 7-day and 30-day follow-up timeframes, the importance of scheduling eligible follow-up visits after discharge, and ensuring that services, diagnoses, and coding meet measure specifications. It also clarifies common areas of confusion, such as discharge-day visits, readmissions, exclusions, and data submission timing.

By understanding these requirements and prioritizing timely outreach, providers can help ensure completed care is captured accurately while supporting continuity of care for members following hospitalization.

[Click here to access the FUH Watchout document](#)



MEDICAL NECESSITY CRITERIA-MASSACHUSETTS

Carelon Behavioral Health's Medical Necessity Criteria (MNC), also known as clinical criteria, are reviewed and updated at least annually to ensure that they reflect the latest developments in serving individuals with behavioral health diagnoses. Carelon Behavioral Health's Corporate Quality Medical Management Committee (CQMMC) adopts, reviews, revises, and approves MNC per client and regulatory requirements.

MNC varies according to state and/or contractual requirements and member benefit coverage. To determine the proper medical necessity criteria, use the following as a guide:

1. For all Medicare members, first identify relevant Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) Criteria.
2. If no CMS criteria exists for Medicare members and for all non-Medicare members, identify relevant custom MNC.
3. If no custom criteria exists for the applicable level of care and the treatment is substance use disorder-related, the American Society of Addiction Medicine (ASAM) criteria would be appropriate.
** Exception: Substance Use Lab Testing Criteria is in InterQual® Behavioral Health Criteria.*
4. If the level of care is not substance use disorder-related, Change Healthcare's Interqual® Behavioral Health Criteria would be appropriate.
5. If 1-4 above are not met, Carelon Behavioral Health's national MNC would be appropriate.

*Please note as of 9/21/2019, Carelon Behavioral Health began utilizing Change Healthcare's Interqual® Behavioral Health Criteria that can be accessed through the [Carelon Behavioral Health website](#).

New EIBI Coverage Update for Individuals with Down Syndrome

Effective June 1, 2026, Early Intensive Behavioral Intervention (EIBI) services will be available to children with a diagnosis of Down syndrome who participate in early intervention programs. This update is reflected in the updated medical necessity criteria document.

MNC varies according to state and/or contractual requirements and member benefit coverage. To determine the proper medical necessity criteria, use the 2026 Medical Necessity Criteria as a guide.

Click here to access the
2026 Medical Necessity Criteria for Massachusetts



NYSDOH ISSUES GUIDANCE ON SUD TYPE OF BILL REPORTING

TO: All New York State Providers

The New York State Department of Health (NYSDOH) is communicating expectations regarding the appropriate reporting of Type of Bill (TOB) values for substance use disorder (SUD) managed care encounters submitted to New York State Medicaid, in alignment with Centers for Medicare and Medicaid Services' (CMS) specifications.

To meet CMS specifications and ensure accurate encounter reporting, NYSDOH is asking SUD providers to submit Facility Type Code values of '86' or '89' in loop 2300, in the Health Claim segment, for element 1331 (ref. CLM05-01) on claims for services using the following rate codes:

Prog	Rate Code	Rate Code / Service Title
Withdrawal and Stabilization	4220	Article 32 Medically Supervised Inpatient Withdrawal
Inpatient Rehabilitation	4213	Article 32 Inpatient Rehabilitation
	4202	Article 32 State Operated Addiction Treatment Center
Residential Services	1144	Stabilization
	1145	Rehabilitation
	1146	Reintegration

SUD providers have been issued guidance on expectations for the submission of the Facility Type Code through the NYS Office for Office of Addiction Supports and Services (OASAS).

Health Plans are expected to work with their contracted SUD providers to ensure encounters for the above services are submitted using the appropriate TOB values.

These encounters should continue to conform to the x12 standards of submission. If there are questions regarding this guidance, please contact ManagedCareEncounterCompliance@health.ny.gov.

Thank you for your attention to this matter and for your continued partnership in supporting compliant and accurate encounter data submission.

STATE-APPROVED CURRICULUM FOR CULTURAL AND LINGUISTIC COMPETENCE FOR BEHAVIORAL HEALTH PROVIDERS

TO: All New York State Medicaid Managed Care Behavioral Health Providers

REMINDER:

The New York State (NYS) Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Department of Health (DOH) direct Medicaid Managed Care Organizations (MMCOs) and their provider networks to demonstrate cultural competence, per the Medicaid Managed Care (MMC)/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract (MMC Model Contract) , Section 15.10(c):

“The Contractor shall ensure the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers’ staff who have regular and substantial contact with Enrollees. The State will provide cultural competence training materials to the Contractor and providers upon request.”

State-approved cultural competence trainings for behavioral health providers include:

1. Two modules found on The Center for Practice Innovations (CPI) platform, see links and instructions on following page.
 - a) Cultural Competence Curriculum; and,
 - b) Using the Cultural Formulation Interview (CFI) module.
2. OASAS-approved training, see link and instructions on following page.



State-approved curriculum for cultural and linguistic competence for behavioral health providers: *continued*

Links and Instructions

1. Center for Practice Innovations (CPI):

Completion of the required modules satisfies the cultural competency training requirement as outlined in the MMC Model Contract. Providers who complete the “Using the Cultural Formulation Interview” module are eligible for continuing education credits.

- Providers can access these training modules through the [CPI learning community](#).
- If a provider’s program does not currently have access to the CPI learning community, the program manager may complete a [brief application](#) to request access to training modules.

2. OASAS-approved training courses:

Completion of an OASAS-approved training satisfies the cultural competency training requirement as outlined in the MMC Model Contract. Providers should retain a copy of the certificate and have it readily available upon request from the MMCO.

- Providers may access a list of OASAS-approved trainers by visiting the [NYS OASAS Training Catalog](#) and clicking the “Cultural Competency” tab located on the left. Providers may reach out directly to enquire about training opportunities, and/or to schedule a training.

Language Access and Working with Interpreters

To support the requirement that staff receive training on the use of interpreters, providers may access the following state resources on best practices:

- OASAS: [Learning Thursdays – Language Access Overview](#)
- OMH: [Language Access Services Contact Information](#)
- NYS Office of General Services (OGS): [Language Access Resources](#)

Questions regarding State-approved curriculum for cultural and linguistic competence can be sent to:

- For OMH providers: OMH-Managed-Care@omh.ny.gov
- For OASAS providers: PICM@oasas.ny.gov
- For DOH providers: OMCmail@health.ny.gov

RESPONDING TO PROVIDER FEEDBACK ON MENTAL HEALTH ADVANCED DIRECTIVES

Thank you to the providers across our network who recently participated in our survey on Mental Health Advanced Directives (MHADs). We appreciate your time, your thoughtful feedback, and your continued partnership in advancing person-centered behavioral health care.

Your responses helped us better understand providers' current level of familiarity with MHADs, identify areas where additional clarification may be helpful, and highlight the types of tools that would be most useful to support implementation. In response, we are sharing resources designed to help providers strengthen their internal processes related to Mental Health Advanced Directives.

As a reminder, Caredon Health of Pennsylvania previously updated the Provider Manual to emphasize provider responsibilities related to recognizing and honoring MHADs, becoming familiar with patients' directives, and incorporating those directives into treatment planning in support of patient autonomy and preferences. The update also highlighted the availability of Commonwealth resources to assist providers in understanding and applying these expectations.

Continues on the following page



Responding to Provider Feedback on Mental Health Advanced Directives *continued*

Sample policy and procedure template

A sample Mental Health Advance Directives policy and procedure template can serve as a helpful starting point for organizations that want to formalize their approach to intake, documentation, record storage, staff responsibilities, and crisis response related to MHADs. This sample is intended as a resource only. Providers should review any policy, procedure, or workflow with their organizational leadership and legal counsel before adoption or implementation.

Review of operational expectations

Recent provider communications have outlined practical steps for operationalizing MHADs in behavioral health settings. These include incorporating a routine MHAD question into intake, requesting and uploading a copy of the directive when available, documenting agent information and relevant dates, educating front-line staff, integrating MHAD review into crisis and discharge planning, engaging individuals and support persons in treatment discussions, and developing an internal policy for how MHADs are stored, flagged, and acted upon.

Resources for individuals who want to create an MHAD

Providers also asked where they can direct individuals who are interested in completing a Mental Health Advance Directive. Previously shared resources include the Pennsylvania Mental Health Consumers' Association, Pennsylvania Protection & Advocacy/Disabilities Law Project, and the Mental Health Association in Pennsylvania. And here are instructions and forms: [Instructions Forms - English.pdf](#)

Thank you again to everyone who participated in the survey. Your feedback is helping shape practical supports for the provider network and strengthen our shared commitment to respectful, person-centered care.

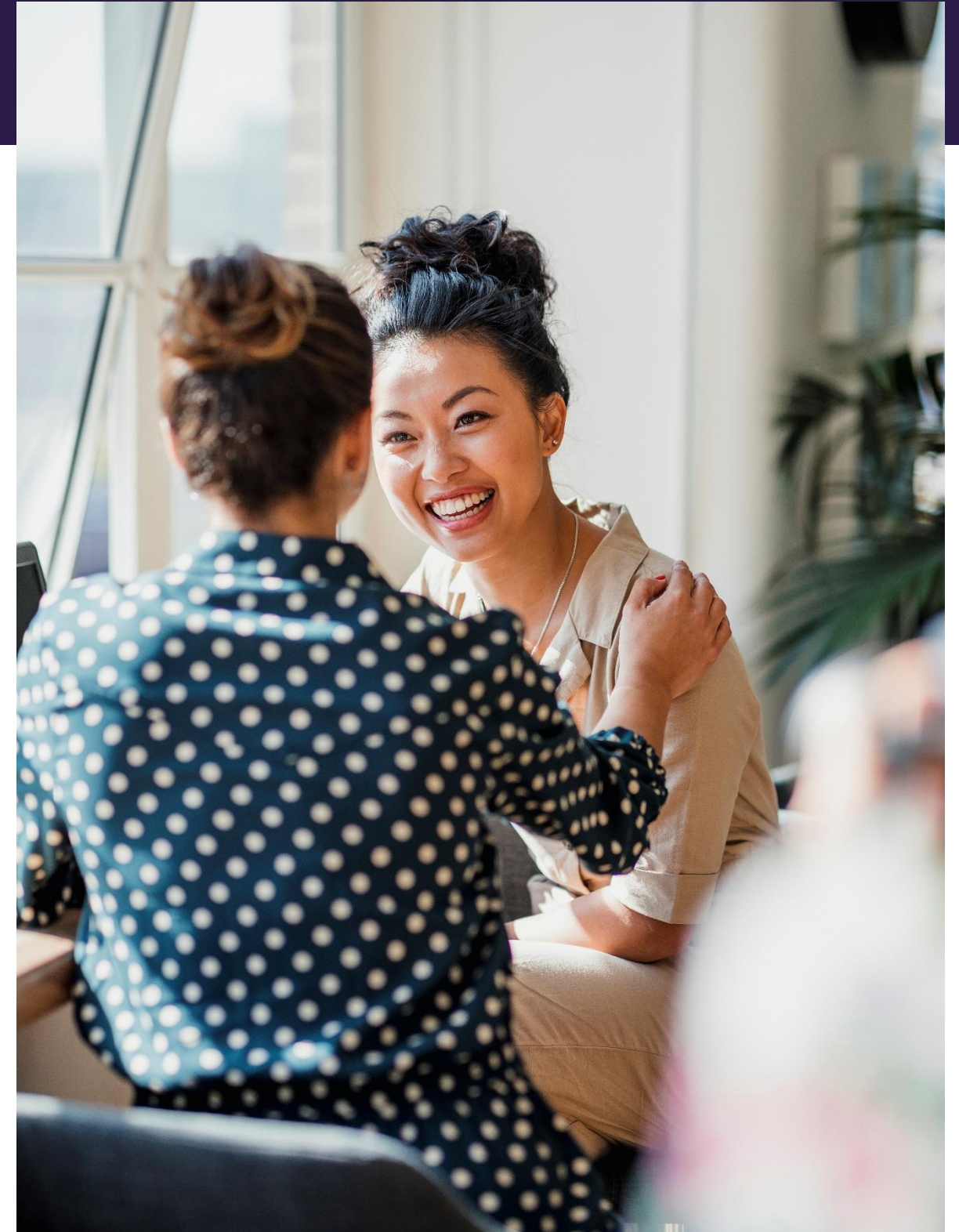
PRACTICAL LEADERSHIP SKILLS FOR SUPERVISORS OF LICENSED CLINICIANS IN BEHAVIORAL HEALTH

- DR. DANA TACCA, VP CLINICAL SERVICES, CARELON OF PENNSYLVANIA

A supervisor in a behavioral health organization must do more than monitor productivity and schedules. Because licensed clinicians make decisions involving assessment, treatment planning, crisis response, documentation, ethics, and client safety, supervisors need leadership practices that support both clinical quality and staff well-being. The most effective behavioral health supervisors create structure, reduce unnecessary barriers, and build a team culture where clinicians can ask for help, raise concerns, and continue developing professionally.

One practical leadership skill is structured, competency-based supervision. The American Psychological Association emphasizes that quality supervision should use a competency framework to strengthen supervisee competence and protect clients, the public, and supervisees (American Psychological Association [APA], 2025). For supervisors, this means supervision should not be limited to asking whether notes are finished or productivity targets are met. A useful supervision agenda should include client risk, ethical concerns, treatment progress, documentation quality, cultural considerations, and clinician development goals. Supervisors can implement this by using a consistent supervision template, reviewing one complex case in depth each week, asking clinicians what support they need, and documenting agreed-upon follow-up steps. Research on routine mental health care also suggests that supervision is widely viewed as important for ongoing learning and clinical support (Choy-Brown & Stanhope, 2018).

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Practical Leadership Skills for Supervisors of Licensed Clinicians in Behavioral Health *continued*

Supervisors should also build psychological safety into daily operations. Psychological safety means staff believe they can speak up with questions, concerns, mistakes, or ideas without being punished or humiliated (Agency for Healthcare Research and Quality [AHRQ], n.d.). In behavioral health, this is essential because clinicians need to discuss suicide risk, mandated reporting, boundary concerns, medication coordination issues, client complaints, documentation errors, and treatment uncertainty. A practical strategy is for the supervisor to open team meetings with questions such as, “What client safety concerns need consultation today?” or “What is getting in the way of good care this week?” When a problem is identified, the supervisor should respond with curiosity before correction: “Walk me through what happened,” “What did you need that you did not have?” and “What can we change in the system to prevent this next time?” Psychological safety supports a culture where team members can identify obstacles, offer improvement ideas, and speak out about safety concerns (AHRQ, n.d.).

Another essential skill is burnout-aware supervision. Behavioral health work can involve high caseloads, crisis exposure, secondary trauma, administrative pressure, and emotionally intense client needs. SAMHSA identifies workload, control, reward, community, fairness, and values as major organizational drivers of burnout (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). A practical supervisor should track more than the number of clients assigned to each clinician; they should also consider acuity, crisis frequency, court involvement, family conflict, trauma exposure, no-show burden, and documentation complexity. Supervisors can reduce burnout risk by reviewing caseload balance monthly, protecting lunch and documentation time when possible, rotating high-intensity assignments, offering debriefing after critical incidents, and advocating upward when productivity expectations conflict with safe care.

Effective supervisors also practice ethical and regulatory leadership. Licensed clinicians are accountable to professional boards, laws, and codes of ethics, so supervisors must be careful not to pressure staff to work outside their scope, ignore risk, alter documentation inaccurately, or place billing above client welfare. A practical approach is to create clear decision pathways for common high-risk situations: suicidal ideation, homicidal ideation, suspected abuse or neglect, client abandonment, confidentiality concerns, subpoenas, releases of information, and documentation corrections. Supervisors should also clarify whether they are providing clinical supervision, administrative supervision, or both. When issues are complex, strong supervisors encourage consultation with clinical directors, compliance officers, legal counsel, ethics boards, or licensing resources rather than expecting one clinician to carry the decision alone.



Practical Leadership Skills for Supervisors of Licensed Clinicians in Behavioral Health *continued*

Finally, behavioral health supervisors need consistent feedback and relational leadership. Clinicians are more likely to perform well when expectations are clear, feedback is timely, and accountability is paired with respect. Supervisors can hold brief monthly check-ins focused on three questions: “What is going well?” “What is getting in your way?” and “What support or development would help you do your best work?” They should recognize strong clinical judgment, not only high productivity. They should also address performance concerns early, specifically, and privately. For example, instead of saying, “Your documentation needs work,” a supervisor might say, “Your treatment plans are clinically thoughtful, but the measurable objectives need to be clearer. Let’s review two examples together and agree on a documentation standard for the next two weeks.”

In summary, practical leadership in behavioral health requires structure, communication, ethical clarity, and attention to clinician well-being. Supervisors can support licensed clinicians by using consistent supervision agendas, encouraging consultation, creating psychological safety, monitoring workload, and acuity, protecting ethical practice, and giving regular feedback. When supervisors balance accountability with support, they strengthen both clinician performance and client care.

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WHAT IS “GAS STATION HEROIN”?

From the Medical Director’s Desk – Mark G. Fuller MD

In April 2026, the Fayette County Coroner, Dr. Bob Baker, issued an urgent warning about the dangers regarding a “dangerous and highly addictive drug,” tianeptine, which is commonly referred to as Gas Station Heroin. Dr. Baker goes on to say, “It’s readily available, very dangerous, and unregulated.” He issued this statement after a local Fayette County woman died of an overdose of tianeptine.

Most health care professionals have never heard of tianeptine and similar drugs which are being sold without regulation in stores all over the US. So what is “Gas Station Heroin” and what do health care professionals need to know about it?

“Gas station heroin” is a street term commonly used to describe products containing tianeptine, a substance marketed in some convenience stores, smoke shops, and gas stations under names such as “ZaZa,” “Neptune’s Fix,” and “Tianna Red.” Although tianeptine is approved as an antidepressant in some countries, it is not approved by the U.S. Food and Drug Administration (FDA) for any medical use. At high doses, tianeptine can produce opioid-like effects, including euphoria, sedation, and relief of withdrawal symptoms, which has led to increasing misuse and dependence. Because these products are often sold as dietary supplements or cognitive enhancers, many consumers mistakenly assume they are safe or legal alternatives to opioids.

The nickname “gas station heroin” reflects both the accessibility of these products and the serious health risks associated with their use. Individuals may develop tolerance, physical dependence, and withdrawal symptoms similar to those seen with opioids, including anxiety, nausea, tremors, sweating, insomnia, and cravings. Severe intoxication can result in respiratory depression, seizures, altered mental status, cardiac complications, and death, particularly when combined with other substances such as alcohol, benzodiazepines, or opioids. Poison control centers across the United States have reported a growing number of calls related to tianeptine exposure in recent years.

Public health officials and addiction specialists are increasingly concerned about the widespread availability and limited regulation of these products. Several states have banned or restricted tianeptine sales, and the FDA has issued warnings about the dangers of these products. Clinicians should consider tianeptine exposure in patients presenting with unexplained opioid-like symptoms or withdrawal, especially when routine toxicology screens are negative. Greater public awareness, regulatory oversight, and education are needed to reduce harm and prevent further misuse of these potentially dangerous substances.

STRENGTHENING RECOVERY THROUGH BETTER COORDINATION: WHY CONTINUED CASE MANAGEMENT MATTERS DURING SUBSTANCE USE TREATMENT

Sarah Haines LCSW, LICSW, Provider Quality Manager

Maintaining member engagement in treatment and supporting successful transitions between levels of care are critical priorities. The literature supports continued case management involvement while a member is actively receiving substance use treatment because it strengthens treatment linkage, retention, care coordination, and continuity across the recovery journey (Hesse et al., 2007; Rapp et al., 2014; Vanderplasschen et al., 2019).

Case management appears to be most valuable when it is not limited to intake or discharge but instead remains active during treatment. That distinction is important. Members in drug and alcohol rehabilitation often need more than clinical treatment alone. Case management plays an important role in addressing the non-clinical barriers that frequently disrupt recovery. Many adults in substance use treatment are not only struggling with cravings or withdrawal. They may also face unstable housing, transportation barriers, unemployment, co-occurring mental health conditions, medical needs, legal issues, and fragmented service systems. Addressing these health-related social needs can reduce barriers to prevent premature discharges, improve follow-up, and support sustained engagement in recovery.

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Strengthening Recovery Through Better Coordination: Why Continued Case Management Matters During Substance Use Treatment *continued*

The evidence on retention and length of stay is especially relevant for providers seeking to improve outcomes. Case management helps members remain engaged long enough to fully benefit from treatment and access the resources needed to support ongoing recovery (Vanderplasschen et al., 2019). In a study of publicly funded substance use treatment programs, case-managed members were 1.6 to 3.6 times more likely to reach treatment lengths associated with better outcomes, and withdrawal management members were 1.7 times more likely to transition to post-detoxification treatment (Shwartz et al., 1997). The case for continued case management is especially strong during transitions between levels of care, when members are at increased risk of disengagement.

Case management improves linkage to treatment and outperforms both motivational interviewing and standard referral processes (Rapp et al., 2008). Research consistently shows that passive referrals, discharge paperwork, and general instructions to “follow up” are less effective than active, relationship-based transition practices. Additional studies show that structured continuity strategies—such as scheduling the next appointment before discharge, introducing the member to the next provider, and reinforcing follow-through—can improve successful transition from residential to outpatient care (Acquavita et al., 2013). Timely follow-up is also critical, as members who attend follow-up care within seven days of residential discharge have substantially better long-term outcomes than those who do not (Proctor et al., 2017). Formal partnerships among hospitals, rehabilitation providers, case management teams, and community-based organizations further strengthen care coordination by creating the infrastructure needed for timely communication, shared accountability, and effective handoffs (Lindenfeld et al., 2025).

The takeaway is straightforward: encouraging continued case management while a member is actively engaged in substance use treatment is a research-supported strategy for improving engagement, strengthening retention, and supporting successful transitions across levels of care. Case management is an adjunct to clinical treatment that improves care coordination, treatment engagement, and continuity across levels of care. This improves the likelihood that members will sustain recovery, remain connected to care, and achieve meaningful long-term outcomes to live the fullest lives possible (Hesse et al., 2007; Vanderplasschen et al., 2019).

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E&M CODING PATTERN REVIEW AND DOCUMENTATION REMINDER

We are noticing a pattern in Evaluation and Management (E&M) billing in which some providers are primarily using the same codes, with a concentration in higher-level established patient visit codes. Although coding should always reflect the services provided and documented, this type of pattern may indicate the need for additional review and education.

For established patient office visits, codes **99212 through 99215** represent varying levels of complexity, medical decision-making, and provider time. In most cases, we expect to see a coding distribution that resembles **a bell curve** across these codes. Typically, lower- and mid-level codes occur more often, while the highest-level codes are used less frequently and only when supported by the documentation.

Maintaining an appropriate distribution of E&M codes is important for compliance, payment integrity, and audit readiness. Providers should assign codes based on the documented services performed, including the complexity of medical decision-making and/or total time spent on the date of the encounter.

When billing patterns are heavily weighted toward **99214 and 99215**, or when one code is used almost exclusively, it may suggest that coding practices are not fully reflecting the variation in patient encounters. Not every visit has the same level of complexity, and documentation should clearly support the code selected.

A balanced use of **99212, 99213, 99214, and 99215** is generally what we expect to see. Patterns that fall outside this expected bell curve may be subject to further review to ensure coding accuracy and alignment with documentation standards.

Our goal is to support providers through education and awareness, while promoting accurate, consistent, and compliant coding practices.

YOUR RIGHTS: COMPLAINTS AND GRIEVANCES (AND A REMINDER FOR PROVIDERS)

Carelon Health of Pennsylvania wants members to know their rights and how to get help. Providers also play an important part. Under the Pennsylvania HealthChoices program, members can file a complaint or a grievance—and network providers must post these notices in all provider offices so members can read them.

Members: You can file a Complaint

You have the right to file a complaint if you have a problem or are unhappy with:

- your mental health or substance use disorder treatment,
- your provider, or
- Carelon.

See: [PA Complaint Flyer](#)

When you file a complaint, Carelon will:

- talk with you to understand your concern,
- contact your provider for a response,
- review records and other information (like rules and timeframes), and
- share the results with you.

You may be asked to share documents (like texts or emails) or provide witnesses. You will also be asked how you want the issue fixed.

Your service provider is not allowed to retaliate (treat you differently) for filing a complaint.

Why file a complaint?

You may want to file a complaint if, for example:

- Carelon says you cannot get a service because it is not covered.
- Carelon did not meet the timeframes for providing a service.
- Carelon will not pay for a service because it is not covered.
- Carelon did not decide a first-level complaint within 30 days.
- Carelon will not pay because the provider was not enrolled in Pennsylvania Medical Assistance.
- Carelon denied your request to dispute a bill (cost sharing, copays, deductibles, coinsurance, or other bills).
- You are unhappy with Carelon or a provider for any other reason.

Your Rights: Complaints and Grievances (and a Reminder for Providers) *continued*

Members: You can file a Grievance

A **grievance** is when you disagree with a decision about the **medical necessity** or **appropriateness** of a covered service requested by you or your provider.

See: [PA Grievance Flyer](#)

If Carelon does not fully approve a service, we will send you a letter that explains how to file. In most cases, you have **60 calendar days** to file a grievance starting on the date you receive that letter.

Get Help (Complaints or Grievances) — 24/7 Support

Call your county's toll-free number (help is available 24/7):

- **Armstrong:** 877-688-5969
- **Beaver:** 877-688-5970
- **Butler:** 877-688-5971
- **Crawford:** 866-404-4561
- **Fayette:** 877-688-5972
- **Indiana:** 877-688-5969
- **Lawrence:** 877-688-5975
- **Mercer:** 866-404-4561
- **Venango:** 866-404-4561
- **Washington:** 877-688-5976
- **Westmoreland:** 877-688-5977

TTY: PA Relay 711

Language help: If English is not your first language, call your county's toll-free number for language help.

Why file a grievance?

You can file a grievance if Carelon:

- denies full or partial payment for a requested service,
- approves the service, but for a smaller amount, scope, or duration, or
- denies the requested service but approves an alternative service instead.

Want to keep getting services while your grievance is reviewed?

If you disagree with a decision to discontinue, reduce, or change your service, you (or your provider) must file:

- within **1 calendar day** for inpatient services, or
- within **15 calendar days** for any other service, from the date on the letter. Your services will continue until a decision is made.

PROVIDERS: Posting These Notices is Required

Pennsylvania HealthChoices Program Standards and Requirements require Carelon to ensure network providers **display information about how to file a Complaint or a Grievance and the Complaint process at all Network Provider offices.**

What to do now (providers):

Post the current [Complaint](#) and [Grievance](#) flyers in a place members can easily see (like the front desk or waiting room). Make sure the flyers stay posted and easy to read at **every** office location.

Posting these notices helps members understand their rights and know where to go for help.

HOW TO FILE A GRIEVANCE

Carelon Health of Pennsylvania, Inc. (Carelon) is committed to ensuring that members and providers have a clear, accessible process for filing grievances. Providers play an important role in supporting members by submitting grievances on their behalf when appropriate.

Submitting a Grievance

If you are filing a grievance on behalf of a member, a completed Grievance Release Form is required. This form authorizes you to act on a member's behalf. Providers may obtain a member's written consent at the time of treatment. However, providers may not require a member to sign a Grievance Release Form as a condition of receiving treatment.

- The Grievance Release Form is available on our website at: <https://providers.pa.carelon.com/providers/provider-forms/>.

Navigate to the "Other Forms" section. No sign-in is required to access the form.

Grievance Release Form Overview

The Grievance Release Form captures key information needed to process a grievance and documents the member's consent for provider representation. The form includes:

- **Member Information:** Name, MA ID, date of birth, and address
- **Provider Information:** Provider name, ID, address, and contact details
- **Service Details:** Dates of service and level of care involved
- **Request Type:** Indicates whether the request is for a grievance, external review, or DHS fair hearing
- **Member Consent:** Signed authorization allowing the provider to act on the member's behalf for the specific episode of care
- **Acknowledgements:** Confirms the member's rights, including the ability to rescind consent at any time and that they will not be held financially responsible regardless of the outcome

How to File a Grievance *continued*

Where to Send the Completed Form

Please submit the completed Grievance Release Form using one of the following methods:

- **Mail:** Carelon Health of Pennsylvania, Inc., Attn: Grievances, PO Box 1840, Cranberry Twp., PA 16066-1840
- **Fax:** (855) 439-2445
- **Email:** sevenfieldspeeroffice@carelon.com

Questions or Need Assistance?

If you have questions about the grievance process or need assistance, please contact us:

- **Phone:** (877) 615-8503
- **Email:** sevenfieldspeeroffice@carelon.com
- **Website:** pa.carelon.com

Continuation Rights Reminder

Always refer to the denial notice for member-specific information regarding continuation rights. Each notice includes the deadline by which a grievance must be filed to preserve continuation rights. In general, a member disputing a decision to discontinue, reduce, or change a current service may continue to receive that service at the previously authorized level pending resolution of the grievance, if the grievance is filed within the required timeframe included in the denial notice. Failure to meet these timeframes may result in the loss of continuation rights.

Thank you for sharing this information with your team. We value your partnership in supporting member rights.

CREATING A CULTURE OF CELEBRATION

Is there a team or program you would like to celebrate? Are you producing outcomes that are making a positive impact on our members? Is there a service delivery that is new and innovative that you believe will produce a positive impact? Are you successfully collaborating with our members' physical health provider(s)? If so, we encourage you to share your outcomes, stories and the stories behind the stories.

Our partnership is a shared journey; we look forward to learning from you and celebrating with you.

Please send your submissions to PAMedicaidProviderRelations@carelon.com.



Creating a Culture of Celebration *continued*

One meaningful way organizations can strengthen employee engagement is by intentionally creating opportunities to celebrate and recognize staff. At Glade Run Lutheran Services, leaders demonstrated this commitment through an annual agency-wide Employee Appreciation Day and Wellness Fair.

This event reflected the organization's recognition that its employees are its greatest asset. By investing in staff appreciation and well-being, Glade Run Lutheran Services helped foster a workplace culture rooted in gratitude, connection, and support.

The day included lunch, agency gear, wellness and self-care activities, games, and raffles, all designed to boost morale, encourage camaraderie, and honor the valuable contributions employees make every day. More than just a celebration, the event serves as a visible reminder that employee well-being matters. Creating a culture of celebration can have a lasting impact, helping employees feel valued, connected, and motivated in the work they do.



TEXAS MEDICAID PEM REVALIDATION AND TRAINING RESOURCES

Texas Medicaid is conducting Provider Enrollment and Management (PEM) revalidations. If you receive a revalidation request, please complete all required steps by the deadline listed in your notice to avoid interruptions to your Medicaid enrollment status.

PEM Revalidation Resource: Use the [Texas HHS resource page](#) for details on Medicaid/CHIP enrollment and revalidation requirements.

What providers should do

- Watch for revalidation notifications and requests for information.
- Submit all requested documentation and attestations by the stated due date.
- Confirm your practice demographic and contact information is up to date.

TRAINING RESOURCES:

For additional guidance and ongoing compliance training, please reference the [Carelon Behavioral Health Provider Training page](#) for provider trainings, including:

- Cultural Competency
- Availability
- Fraud, Waste and Abuse (FWA)